



MEDICARE ENROLLMENT APPLICATION

**Clinics/Group Practices
and Certain Other Suppliers**

CMS-855B

SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.

SEE PAGE 2 FOR INFORMATION ON WHERE TO MAIL THIS APPLICATION.

**SEE PAGE 34 TO FIND A LIST OF THE SUPPORTING DOCUMENTATION
THAT MUST BE SUBMITTED WITH THIS APPLICATION.**



WHO SHOULD SUBMIT THIS APPLICATION

The following suppliers must complete this application to initiate the enrollment process:

Ambulance Service Supplier	Mammography Center
Ambulatory Surgical Center	Mass Immunization (Roster Biller Only)
Clinic/Group Practice	Portable X-ray Supplier
Competitive Acquisition Program (CAP)	Radiation Therapy Center
Part B Drug Vendor	Slide Preparation Facility
Independent Clinical Laboratory	Voluntary Health/Charitable Agency
Independent Diagnostic Testing Facility	

If your supplier type is not listed above, contact the fee-for-service contractor before you submit this application.

Complete and submit this application if you are an organization/group that plans to bill Medicare and you are:

- A **medical practice or clinic that will bill for Medicare Part B services**, such as group practices, clinics, independent laboratories, portable x-ray suppliers, etc.
- A **hospital or other medical practice or clinic** that may bill for Medicare Part A services but will also bill for Medicare Part B practitioner services or provide purchased laboratory tests to other entities that bill Medicare Part B.
- **Currently enrolled with a Medicare fee-for-service contractor but need to enroll in another fee-for-service contractor's jurisdiction** (e.g., you have opened a practice location in a geographic territory serviced by another Medicare fee-for-service contractor).
- **Currently enrolled in Medicare and need to make changes to your enrollment data** (e.g., you have added or changed a practice location). Changes must be reported within 90 days of the effective date of the change.

BILLING NUMBER INFORMATION

The Medicare Identification Number, often referred to as a Provider Identification Number (PIN), is a generic term for any number other than the National Provider Identifier (NPI) that is used by a supplier to bill the Medicare program.

The NPI is the standard unique health identifier for health care providers and is assigned by the National Plan and Provider Enumeration System (NPPES). As a Medicare health care supplier, you must obtain an NPI prior to enrolling in Medicare or before submitting a change for your existing Medicare enrollment information. Applying for an NPI is a process separate from Medicare enrollment. As a supplier, it is your responsibility to determine if you have "subparts." A subpart is a component of an organization (supplier) that furnishes healthcare and is not itself a legal entity. If you do have subparts, you must determine if they should obtain their own unique NPIs. Before you complete this enrollment application, you need to make those determinations and obtain NPI(s) accordingly.

To obtain an NPI, you may apply online at <https://NPPES.cms.hhs.gov>. For more information about subparts, visit www.cms.hhs.gov/NationalProvIdentStand to view the "Medicare Expectations Subparts Paper."

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

- Type or print all information so that it is legible. Do not use pencil.
- Report additional information within a section by copying and completing that section for each additional entry.
- Attach all required supporting documentation.
- Keep a copy of your completed Medicare enrollment package for your records.
- Send the completed application with original signatures and all required documentation to your designated Medicare fee-for-service contractor.

AVOID DELAYS IN YOUR ENROLLMENT

To avoid delays in the enrollment process, you should:

- Complete all required sections.
- Ensure that the legal business name shown in Section 2 matches the name on the tax documents.
- Ensure that the correspondence address shown in Section 2 is the supplier's address.
- Enter your NPI in the applicable section.
- Enter all applicable dates.
- Ensure that the correct person signs the application.

Note: A billing agent representative may not sign the application.

- Send your application and all supporting documentation to the designated fee-for-service contractor.

ADDITIONAL INFORMATION

For additional information regarding the Medicare enrollment process, visit www.cms.hhs.gov/MedicareProviderSupEnroll.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support and validate information reported on the application. You are responsible for providing this documentation in a timely manner.

The information you provide on this application will not be shared. It is considered to be protected under 5 U.S.C. Section 552(b)(4) and/or (b)(6), respectively. For more information, see the last page of this application for the Privacy Act Statement.

MAIL YOUR APPLICATION

The Medicare fee-for-service contractor (also referred to as a carrier or a Medicare administrative contractor) that services your State is responsible for processing your enrollment application. To locate the mailing address for your fee-for-service contractor, go to www.cms.hhs.gov/MedicareProviderSupEnroll.

SECTION 1: BASIC INFORMATION

NEW ENROLLEES AND THOSE WITH A NEW TAX ID NUMBER

If you are:

- Enrolling in the Medicare program for the first time with this Medicare fee-for-service contractor under this tax identification number.
- Already enrolled with a Medicare fee-for-service contractor but are establishing a practice location in another fee-for-service contractor's jurisdiction.
- Enrolled with a Medicare fee-for-service contractor but have a new tax identification number. If you are reporting a change to your tax identification number, you must complete a new application.
- A hospital or an individual hospital department that is enrolling with a fee-for-service contractor to bill for Part B services.

ENROLLED MEDICARE SUPPLIERS

The following actions apply to Medicare suppliers already enrolled in the program:

Reactivation

To reactivate your Medicare billing privileges, submit this enrollment application. In addition, prior to being reactivated, you must be able to submit a valid claim and meet all current requirements for your supplier type before reactivation may occur.

Voluntary Termination

A supplier should voluntarily terminate its Medicare enrollment when it:

- Will no longer be rendering services to Medicare patients, or
- Is planning to cease (or has ceased) operations.

Change of Ownership

If a hospital, ambulatory surgical center, or portable X-ray supplier is undergoing a change of ownership (CHOW) in accordance with the principles outlined in 42 CFR 489.18, the entity must submit a new application for the new ownership.

Change of Information

A change of information should be submitted if you are changing, adding or deleting information under your current tax identification number.

If you are already enrolled in Medicare and are not receiving Medicare payments via EFT, any change to your enrollment information will require you to submit a CMS-588 form. All future payments will then be received via EFT.

Revalidation

CMS may require you to submit or update your enrollment information. The fee-for-service contractor will notify you when it is time for you to revalidate your enrollment information. Do not submit a revalidation application until you have been contacted by the fee-for-service contractor.

SECTION 1: BASIC INFORMATION

ALL APPLICANTS MUST COMPLETE THIS SECTION (See instructions for details.)

A. Check one box and complete the required sections.

REASON FOR APPLICATION	BILLING NUMBER INFORMATION	REQUIRED SECTIONS
<input type="checkbox"/> You are a new enrollee in Medicare	Enter your Medicare Identification Number (<i>if issued</i>) and the NPI you would like to link to this number in Section 4.	Complete all sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attachment 2
<input type="checkbox"/> You are enrolling in another fee-for-service contractor’s jurisdiction	Enter your Medicare Identification Number (<i>if issued</i>) and the NPI you would like to link to this number in Section 4.	Complete all sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attachment 2
<input type="checkbox"/> You are reactivating your Medicare enrollment	Enter your Medicare Identification Number (<i>if issued</i>) and the NPI you would like to link to this number in Section 4.	Complete all sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attachment 2
<input type="checkbox"/> You are voluntarily terminating your Medicare enrollment. (This is not the same as “opting out” of the program)	Effective Date of Termination	Sections 1A, 2B1, 13, and either 15 or 16 If you are terminating an employment arrangement with a physician assistant, complete Sections 1A, 2G, 13, and either 15 or 16
	Medicare Identification Number to Terminate (<i>if issued</i>): NPI number (<i>if issued</i>):	
<input type="checkbox"/> You are changing your Medicare information	Medicare Identification Number (<i>if issued</i>): NPI:	Go to Section 1B
<input type="checkbox"/> You are revalidating your Medicare enrollment	Enter your Medicare Identification Number (<i>if issued</i>) and the NPI you would like to link to this number in Section 4.	Complete all sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attachment 2

SECTION 1: BASIC INFORMATION (Continued)

B. Check all that apply and complete the required sections:

REQUIRED SECTIONS

<input type="checkbox"/> Identifying Information	1, 2 (complete only those sections that are changing), 3, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Adverse Legal Actions/Convictions	1, 2B1, 3, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Practice Location Information, Payment Address & Medical Record Storage Information	1, 2B1, 3, 4 (complete only those sections that are changing), 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Change of Ownership (Hospitals, Portable X-Ray Suppliers & Ambulatory Surgical Centers Only)	Complete all sections and provide a copy of the sales agreement
<input type="checkbox"/> Ownership Interest and/or Managing Control Information (Organizations)	1, 2B1, 3, 5, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Ownership Interest and/or Managing Control Information (Individuals)	1, 2B1, 3, 6, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Billing Agency Information	1, 2B1, 3, 8 (complete only those sections that are changing), 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Authorized Official(s)	1, 2B1, 3, 13 , and either 15 (if you are an authorized official) or 16 (if you are a delegated official), and 6 for the signer if that authorized or delegated official has not been established for this supplier
<input type="checkbox"/> Delegated Official(s) (Optional)	1, 2B1, 3, 13, 15 and 16

SECTION 1: BASIC INFORMATION (Continued)

ATTACHMENT 1—AMBULANCE SERVICE SUPPLIERS (ONLY)	REQUIRED SECTIONS
<input type="checkbox"/> Geographic Area	1, 2A2, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 1(A)
<input type="checkbox"/> State License Information	1, 2A2, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 1(B)
<input type="checkbox"/> Paramedic Intercept Services Information	1, 2A2, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 1(C)
<input type="checkbox"/> Vehicle Information	1, 2A2, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 1(D)

ATTACHMENT 2—INDEPENDENT DIAGNOSTIC TESTING FACILITIES (ONLY)	REQUIRED SECTIONS
<input type="checkbox"/> CPT-4 and HCPCS Codes	1, 2A2, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(B)
<input type="checkbox"/> Interpreting Physician Information	1, 2A2, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(C)
<input type="checkbox"/> Personnel (Technicians) Who Perform Tests	1, 2A2, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(D)
<input type="checkbox"/> Supervising Physician(s)	1, 2A2, 3, 13, and 15 if you are the authorized official or 16 if you are the delegated official Attachment 2(E)

SECTION 2: IDENTIFYING INFORMATION

A. TYPE OF SUPPLIER

Check the appropriate box to identify the type of supplier you are enrolling as with Medicare. If you are more than one type of supplier, submit a separate application for each type. If you change the type of service that you provide (i.e., become a different supplier type), submit a new application.

Your organization must meet all Federal and State requirements for the type of supplier checked below. If you are a single specialty clinic/group practice, the specialty must be reported.

TYPE OF SUPPLIER: (check one only)

- | | |
|--|--|
| <input type="checkbox"/> Ambulance Service Supplier | <input type="checkbox"/> Independent Clinical Laboratory |
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Independent Diagnostic Testing Facility |
| <input type="checkbox"/> Clinic/Group Practice | <input type="checkbox"/> Mammography Center |
| <input type="checkbox"/> Single Specialty Clinic _____
<i>Provide Speciality</i> | <input type="checkbox"/> Mass Immunization (Roster Biller Only) |
| <input type="checkbox"/> Multi-Specialty Clinic | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Hospital Department(s) | <input type="checkbox"/> Portable X-ray Supplier |
| <input type="checkbox"/> Public Health/Welfare Agency | <input type="checkbox"/> Radiation Therapy Center |
| <input type="checkbox"/> Physical/Occupational Therapy Group
in Private Practice | <input type="checkbox"/> Slide Preparation Facility |
| <input type="checkbox"/> Competitive Acquisition Program
(CAP) Part B Drug Vendor | <input type="checkbox"/> Voluntary Health/Charitable Agency |
| | <input type="checkbox"/> Other (Specify): _____ |

B. SUPPLIER IDENTIFICATION INFORMATION

1. BUSINESS INFORMATION

Legal Business Name (not "Doing Business As") as reported to the Internal Revenue Service

Tax Identification Number

Other Name

Type of Other Name

- Former Legal Business Name
 Doing Business As Name
 Other (specify): _____

Identify the type of organizational structure for this supplier (Check one):

- Corporation Sole Proprietor Partnership LLC Other (Specify): _____

Incorporation Date (mm/dd/yyyy) (if applicable)

State Where Incorporated (if applicable)

SECTION 2: IDENTIFYING INFORMATION (Continued)

2. STATE LICENSE INFORMATION/CERTIFICATION INFORMATION

Provide the following information if the supplier has a State license/certification to operate as the supplier type for which you are enrolling.

State License Information

License Not Applicable

License Number	State Where Issued
Effective Date <i>(mm/dd/yyyy)</i>	Expiration/Renewal Date <i>(mm/dd/yyyy)</i>

Certification Information

Certification Not Applicable

Certification Number	State Where Issued
Effective Date <i>(mm/dd/yyyy)</i>	Expiration/Renewal Date <i>(mm/dd/yyyy)</i>

3. CORRESPONDENCE ADDRESS

Provide contact information for the entity or person listed in Question 1 of this section. Once enrolled, the information provided below will be used by the fee-for-service contractor if it needs to contact you directly. This address cannot be a billing agency's address.

Mailing Address Line 1 *(Street Name and Number)*

Mailing Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number <i>(if applicable)</i>	E-mail Address <i>(if applicable)</i>

C. HOSPITALS ONLY

This section should only be completed by hospitals that are currently enrolled or enrolling with a fee-for-service contractor (the Part A Medicare contractor), and will be billing a fee-for-service contractor for Medicare Part B services, as follows:

- Hospitals that need departmental billing numbers to bill for Part B practitioner services.
- Hospitals requiring a Part B billing number to provide pathology services.
- Hospitals requiring a Medicare Part B billing number to provide purchased tests to other Medicare Part B billers.
- If the hospital requires more than one departmental Part B billing number, list each department needing a number.

If your organization is not a hospital, and believes it will need a Part B billing number, contact the local fee-for-service contractor to determine if this form should be submitted.

SECTION 2: IDENTIFYING INFORMATION (Continued)

C. HOSPITALS ONLY (Continued)

NOTE: If your hospital is enrolling a clinic that is not provider-based, do not complete this section. Check “Clinic/Group Practice” in Section 2A and complete this entire application for the clinic.

- Are you going to:
 bill for the entire hospital with one billing number? (If yes, continue to Section 2D.)
 separately bill for each hospital department? (If yes, answer Question 2.)
- List the hospital departments for which you plan to bill separately:

Department	Medicare Identification Number	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. COMMENTS/SPECIAL CIRCUMSTANCES

Explain any unique circumstances concerning your practice location, the method by which you render health care services, etc.

E. PHYSICAL THERAPY (PT) AND OCCUPATIONAL THERAPY (OT) GROUPS ONLY

- Are all of the group’s PT/OT services rendered in patients’ homes or in the group’s private office space? YES NO
- Does this group maintain private office space? YES NO
- Does this group own, lease, or rent its private office space? YES NO
- Is this private office space used exclusively for the group’s private practice? YES NO
- Does this group provide PT/OT services outside of its office and/or patients’ homes? YES NO

If you responded YES to any of the questions 2–5 above, submit a copy of the lease agreement that gives the group exclusive use of the facilities for PT/OT services.

F. ACCREDITATION FOR AMBULATORY SURGICAL CENTERS (ASCs) ONLY

Is this ASC accredited? YES NO

If YES, complete the following:

Date of Accreditation (mm/dd/yyyy) _____

Name of Accrediting Body _____

SECTION 2: IDENTIFYING INFORMATION (Continued)**G. TERMINATION OF PHYSICIAN ASSISTANTS (ONLY)**

Complete this section to delete employed physician assistants from your group or clinic.

Effective Date of Departure	Physician Assistant's Name	Physician Assistant's Medicare Identification Number	Physician Assistant's NPI
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS

This section captures information on adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending. If you are uncertain as to whether an action falls within one of the adverse legal action categories or whether a name reported on this application has an adverse legal action, query the Healthcare Integrity and Protection Data Bank. For information on how to access the Data Bank, call 1-800-767-6732 or visit www.npdb-hipdb.com. There is a charge for using this service.

ADVERSE LEGAL ACTIONS THAT MUST BE REPORTED

Convictions

1. The provider, supplier, or any owner of the provider or supplier was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interest of the program and its beneficiaries.

Offenses include:

- Felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicare program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act.
2. Any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
3. Any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
4. Any felony or misdemeanor conviction, under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
5. Any felony or misdemeanor conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
4. Any current Medicare payment suspension under any Medicare billing number.
5. Any Medicare revocation of any Medicare billing number.

SECTION 3: ADVERSE LEGAL ACTIONS/CONVICTIONS (Continued)

ADVERSE LEGAL HISTORY

1. Has your organization, under any current or former name or business identity, ever had an adverse legal action listed on page 11 of this application imposed against it?

YES—Continue Below NO—Skip to Section 4

2. If yes, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation and resolution.

Adverse Legal Action	Date	Taken By	Resolution
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 4: PRACTICE LOCATION INFORMATION

INSTRUCTIONS

This section captures information about the physical location(s) where you currently provide health care services. If you operate a mobile facility or portable unit, provide the address for the “Base of Operations,” as well as vehicle information and the geographic area serviced by these facilities or units.

Only report those practice locations within the jurisdiction of the Medicare fee-for-service contractor to which you will submit this application. If you have practice locations in another Medicare fee-for-service contractor’s jurisdiction, complete a separate enrollment application (CMS-855B) for those practice locations and submit it to the Medicare fee-for-service contractor that has jurisdiction over those locations.

Provide the specific street address as recorded by the United States Postal Service. Do not provide a P.O. Box. If you provide services in a hospital and/or other health care facility for which you bill Medicare directly for the services rendered at that facility, provide the name and address of the hospital or facility.

Mobile Facility and/or Portable Unit

A “mobile facility” is generally a mobile home, trailer, or other large vehicle that has been converted, equipped, and licensed to render health care services. These vehicles usually travel to local shopping centers or community centers to see and treat patients inside the vehicle.

A “portable unit” is when the supplier transports medical equipment to a fixed location (e.g., physician’s office, nursing home) to render services to the patient.

The most common types of mobile facilities/portable units are mobile IDTFs, portable X-ray, portable mammography, and mobile clinics. Physical therapists and other medical practitioners (e.g., physicians, nurse practitioners, physician assistants) who perform services at multiple locations (e.g., house calls, assisted living facilities) are not considered to be mobile facilities/portable units.

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

A. PRACTICE LOCATION INFORMATION

If you see patients **in more than one practice location**, copy and complete Section 4A for each location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

If you are enrolling for the first time, or if you are adding a new practice location, the date you provide should be the date you saw your first Medicare patient at this location.

Practice Location Name (*"Doing Business As" name if different from Legal Business Name*)

Practice Location Address Line 1 (*Street Name and Number*)

Practice Location Address Line 2 (*Suite, Room, etc.*)

City/Town

State

ZIP Code +4

Telephone Number

Fax Number (*if applicable*)

E-mail Address (*if applicable*)

Date you first started rendering services to Medicare patients at this practice location (*mm/dd/yyyy*)

Medicare Identification Number (*if issued*)

National Provider Identifier

Is this practice location a (*check one*):

Group practice office/clinic

Retirement/assisted living community

Hospital

Other health care facility (specify): _____

CLIA Number for this location (*if applicable*)

Attach a copy of the most current CLIA certifications for each of the practice locations reported on this application.

FDA/Radiology (Mammography) Certification Number(s) for this location (*if applicable*)

Attach a copy of the most current FDA certifications for each of the practice locations reported on this application.

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

B. WHERE DO YOU WANT REMITTANCE NOTICES OR SPECIAL PAYMENTS SENT?

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Medicare will issue payments via electronic funds transfer (EFT). Since payments will be made by EFT, the “Special Payments” address should indicate where all other payment information (e.g., remittance notices, special payments) should be sent.

- “Special Payments” address is the same as the practice location (only one address is listed in Section 4A). Skip to Section 4C.
- “Special Payments” address is different than that listed in Section 4A, or multiple locations are listed. Provide address below.

“Special Payments” Address Line 1 (*PO Box or Street Name and Number*)

“Special Payments” Address Line 2 (*Suite, Room, etc.*)

City/Town	State	ZIP Code + 4
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C. WHERE DO YOU KEEP PATIENTS’ MEDICAL RECORDS?

If you store patients’ medical records (current and/or former patients) at a location other than the location in Section 4A or 4E, complete this section with the address of the storage location.

Post Office boxes and drop boxes are not acceptable as physical addresses where patients’ records are maintained. For IDTFs and mobile facilities/portable units, the patients’ medical records must be under the supplier’s control. The records must be the supplier’s records, not the records of another supplier. If this section is not completed, you are indicating that all records are stored at the practice locations reported in Section 4A or 4E.

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

First Medical Record Storage Facility (for current and former patients)

Storage Facility Address Line 1 (*Street Name and Number*)

Storage Facility Address Line 2 (*Suite, Room, etc.*)

City/Town	State	ZIP Code + 4
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Second Medical Record Storage Facility (for current and former patients)

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Storage Facility Address Line 1 (*Street Name and Number*)

Storage Facility Address Line 2 (*Suite, Room, etc.*)

City/Town	State	ZIP Code + 4
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SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

D. RENDERING SERVICES IN PATIENTS' HOMES

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Furnish the city/town, State and ZIP code for all locations where health care services are rendered in patients' homes. If you provide health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate CMS-855B enrollment application for each Medicare fee-for-service contractor's jurisdiction.

If you are adding or deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

Entire State of _____

If you are providing services in selected cities/towns, furnish the locations below. Only list ZIP codes if you are not servicing the entire city/town.

City/Town	State	ZIP Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

E. BASE OF OPERATIONS ADDRESS FOR MOBILE OR PORTABLE SUPPLIERS (LOCATION OF BUSINESS OFFICE OR DISPATCHER/SCHEDULER)

The base of operations is the location from where personnel are dispatched, where mobile/portable equipment is stored, and when applicable, where vehicles are parked when not in use.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Check here and skip to Section 4F if the “Base of Operations” address is the same as the “Practice Location” listed in Section 4A.

Street Address Line 1 (*Street Name and Number*)

Street Address Line 2 (*Suite, Room, etc.*)

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number (<i>if applicable</i>)	E-mail Address (<i>if applicable</i>)

F. VEHICLE INFORMATION

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not provide information about vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor’s office) or ambulance vehicles. If more than two vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. If you are a new enrollee, check “add.”

CHECK ONE FOR EACH VEHICLE	Type of Vehicle (<i>van, mobile home, trailer, etc.</i>)	Vehicle Identification Number
<input type="checkbox"/> CHANGE <input type="checkbox"/> ADD <input type="checkbox"/> DELETE		
Effective Date:		
<input type="checkbox"/> CHANGE <input type="checkbox"/> ADD <input type="checkbox"/> DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

G. GEOGRAPHIC LOCATION FOR MOBILE OR PORTABLE SUPPLIERS WHERE THE BASE OF OPERATIONS AND/OR VEHICLE RENDERS SERVICES

Provide the city/town, State, and ZIP Code for all locations where mobile and/or portable services are rendered.

NOTE: If you provide mobile or portable health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855B) for each Medicare fee-for-service contractor's jurisdiction.

INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

City/Town	State	ZIP Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DELETIONS

If you are deleting an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

Entire State of _____

If services you are deleting are furnished in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

City/Town	State	ZIP Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS)

NOTE: ONLY REPORT ORGANIZATIONS IN THIS SECTION. INDIVIDUALS MUST BE REPORTED IN SECTION 6.

Complete this section with information about all organizations that have 5 percent or more (direct or indirect) ownership interest of, any partnership interest in, and/or managing control of, the supplier identified in Section 2, as well as information on any adverse legal actions that have been imposed against that organization. For examples of organizations that should be reported here, visit our Web site: www.cms.hhs.gov/MedicareProviderSupEnroll. If there is more than one organization that should be reported, copy and complete this section for each.

MANAGING CONTROL (ORGANIZATIONS)

Any organization that exercises operational or managerial control over the supplier, or conducts the day-to-day operations of the supplier, is a managing organization and must be reported. The organization need not have an ownership interest in the supplier in order to qualify as a managing organization. For instance, it could be a management services organization under contract with the supplier to furnish management services for the business.

SPECIAL TYPES OF ORGANIZATIONS

Governmental/Tribal Organizations: If a Federal, State, county, city or other level of government, or an Indian tribe, will be legally and financially responsible for Medicare payments received (including any potential overpayments), the name of that government or Indian tribe should be reported as an owner. The supplier must submit a letter on the letterhead of the responsible government (e.g., government agency) or tribal organization that attests that the government or tribal organization will be legally and financially responsible in the event that there is any outstanding debt owed to CMS. This letter must be signed by an appointed or elected official of the government or tribal organization who has the authority to legally and financially bind the government or tribal organization to the laws, regulations, and program instructions of Medicare.

Non-Profit, Charitable and Religious Organizations: Many non-profit organizations are charitable or religious in nature, and are operated and/or managed by a board of trustees or other governing body. The actual name of the board of trustees or other governing body should be reported in this section. While the organization should be listed in Section 5, individual board members should be listed in Section 6. Each non-profit organization should submit a copy of a 501(c)(3) document verifying its non-profit status.

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) (Continued)

All organizations that have any of the following must be reported in Section 5:

- 5 percent or more ownership of the supplier,
- Managing control of the supplier, or
- A partnership interest in the supplier, regardless of the percentage of ownership the partner has.

Owning/Managing organizations are generally one of the following types:

- Corporations (including non-profit corporations)
- Partnerships and Limited Partnerships (as indicated above)
- Limited Liability Companies
- Charitable and/or Religious organizations
- Governmental and/or Tribal organizations

A. ORGANIZATION WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL—IDENTIFICATION INFORMATION

Not Applicable

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Check all that apply:

- 5 Percent or More Ownership Interest Partner Managing Control

Legal Business Name as Reported to the Internal Revenue Service

“Doing Business As” Name *(if applicable)*

Address Line 1 *(Street Name and Number)*

Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4	NPI <i>(if issued)</i>
Tax Identification Number <i>(Required)</i>		Medicare Identification Number(s) <i>(if issued)</i>	

SECTION 5: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (ORGANIZATIONS) (Continued)

B. ADVERSE LEGAL HISTORY

If reporting a change to existing information, check “Change,” provide the effective date of the change, and complete the appropriate fields in this section.

Change Effective Date: _____

1. Has this organization in Section 5A, under any current or former name or business identity, ever had an adverse legal action listed on page 11 of this application imposed against it?

<input type="checkbox"/> YES – Continue Below <input type="checkbox"/> NO – Skip to Section 6

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution.

Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action	Date	Taken By	Resolution
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS)

NOTE: Only Individuals should be reported in Section 6. Organizations must be reported in Section 5. For more information on “direct” and “indirect” owners, go to www.cms.hhs.gov/MedicareProviderSupEnroll.

The supplier MUST have at least ONE owner and/or managing employee.

The following individuals must be reported in Section 6A:

- All persons who have a 5 percent or greater direct or indirect ownership interest in the supplier;
- If (and only if) the supplier is a corporation (whether for-profit or non-profit), all officers and directors of the supplier;
- All managing employees of the supplier;
- All individuals with a partnership interest in the supplier, regardless of the percentage of ownership the partner has; and
- Authorized and delegated officials.

Example: A supplier is 100 percent owned by Company C, which itself is 100 percent owned by Individual D. Assume that Company C is reported in Section 5A as an owner of the supplier. Assume further that Individual D, as an indirect owner of the supplier, is reported in Section 6A1. Based on this example, the supplier would check the “5 percent or Greater Direct/Indirect Owner” box in Section 6A2.

NOTE: All partners within a partnership must be reported on this application. This applies to both “General” and “Limited” partnerships. For instance, if a limited partnership has several limited partners and each of them only has a 1 percent interest in the supplier, each limited partner must be reported in this application, even though each owns less than 5 percent. The 5 percent threshold primarily applies to corporations and other organizations that are not partnerships.

Non-Profit, Charitable or Religious Organizations: If you are a non-profit charitable or religious organization that has no organizational or individual owners (only board members, directors or managers), you should submit a 501(c)(3) document verifying non-profit status with your application.

For purposes of this application, the terms “officer,” “director,” and “managing employee” are defined as follows:

Officer is any person whose position is listed as being that of an officer in the supplier’s “articles of incorporation” or “corporate bylaws,” or anyone who is appointed by the board of directors as an officer in accordance with the supplier’s corporate bylaws.

Director is a member of the supplier’s “board of directors.” It does not necessarily include a person who may have the word “director” in his/her job title (e.g., departmental director, director of operations). Moreover, where a supplier has a governing body that does not use the term “board of directors,” the members of that governing body will still be considered “directors.” Thus, if the supplier has a governing body titled “board of trustees” (as opposed to “board of directors”), the individual trustees are considered “directors” for Medicare enrollment purposes.

Managing Employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the supplier, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the supplier.

NOTE: If a governmental or tribal organization will be legally and financially responsible for Medicare payments received (per the instructions for Governmental/Tribal Organizations in Section 5), the supplier is only required to report its managing employees in Section 6. Owners, partners, officers, and directors do not need to be reported, except those who are listed as authorized or delegated officials on this application.

SECTION 6: OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION (INDIVIDUALS) (Continued)

Any information on adverse legal actions that have been imposed against the individuals reported in this section must be furnished. If there is more than one individual, copy and complete this section for each individual.

A. INDIVIDUALS WITH OWNERSHIP INTEREST AND/OR MANAGING CONTROL — IDENTIFICATION INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section. The name, date of birth, and social security number of each person listed in this Section must coincide with the individual's information as listed with the Social Security Administration.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

1. First Name	Middle Initial	Last Name	Jr., Sr., etc.
Social Security Number <i>(Required)</i>	Date of Birth <i>(mm/dd/yyyy)</i>	Medicare Identification Number <i>(if issued)</i>	NPI <i>(if issued)</i>

2. What is the above individual's relationship with the supplier in Section 2A? *(Check all that apply.)*

- | | |
|--|---|
| <input type="checkbox"/> 5 Percent or Greater Direct/Indirect Owner
<i>(see Section 5 for definition)</i> | <input type="checkbox"/> Director/Officer |
| <input type="checkbox"/> Partner | <input type="checkbox"/> Contracted Managing Employee |
| <input type="checkbox"/> Managing Employee (W-2) | <input type="checkbox"/> Other _____ |

B. ADVERSE LEGAL HISTORY

Complete this section for the individual reported in Section 6A above. If reporting a change to existing information, check "change," provide the effective date of the change and complete the appropriate fields in this section.

Change Effective Date: _____

1. Has this individual in Section 6A, under any current or former name or business entity, ever had an adverse legal action listed on page 11 of this application imposed against him/her?

YES—Continue Below
 NO—Skip to Section 8

2. If YES, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action	Date	Taken By	Resolution
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION 7: FOR FUTURE USE (This Section Not Applicable)

SECTION 8: BILLING AGENCY INFORMATION

A billing agency is a company or individual that you contract with to prepare and submit your claims. If you use a billing agency, you are responsible for the claims submitted on your behalf.

Check here if this section does not apply and skip to Section 13.

BILLING AGENCY NAME AND ADDRESS

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Legal Business/Individual Name as Reported to the Social Security Administration or the Internal Revenue Service	Tax Identification/Social Security Number <i>(required)</i>
--	---

“Doing Business As” Name *(if applicable)*

Billing Agency Street Address Line 1 *(Street Name and Number)*

Billing Agency Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4
Telephone Number	Fax Number <i>(if applicable)</i>	E-mail Address <i>(if applicable)</i>

SECTION 9: FOR FUTURE USE (This Section Not Applicable)

SECTION 10: FOR FUTURE USE (This Section Not Applicable)

SECTION 11: FOR FUTURE USE (This Section Not Applicable)

SECTION 12: FOR FUTURE USE (This Section Not Applicable)

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is either an authorized or delegated official, check the appropriate box below and skip to the section as indicated.

- Contact an Authorized Official listed in Section 15
- Contact an Delegated Official listed in Section 16

First Name	Middle Initial	Last Name	
Telephone Number		Fax Number <i>(if applicable)</i>	
Address Line 1 <i>(Street Name and Number)</i>			
Address Line 2 <i>(Suite, Room, etc.)</i>			
City/Town		State	ZIP Code + 4
E-mail Address			

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION

This section explains the penalties for deliberately falsifying information in this application to gain or maintain enrollment in the Medicare program.

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry.

Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000 (18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against any individual who, “knowingly and willfully,” makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a Federal health care program.

The offender is subject to fines of up to \$25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729, imposes civil liability, in part, on any person who:
 - a) knowingly presents, or causes to be presented, to an officer or any employee of the United States Government a false or fraudulent claim for payment or approval;
 - b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
 - c) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid.

The Act imposes a civil penalty of \$5,000 to \$10,000 per violation, plus three times the amount of damages sustained by the Government.

4. Section 1128A(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency...a claim...that the Secretary determines is for a medical or other item or service that the person knows or should know:
 - a) was not provided as claimed; and/or
 - b) the claim is false or fraudulent.

This provision authorizes a civil monetary penalty of up to \$10,000 for each item or service, an assessment of up to three times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. 18 U.S.C. 1035 authorizes criminal penalties against individuals in any matter involving a health care benefit program who knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items or services. The individual shall be fined or imprisoned up to 5 years or both.

SECTION 14: PENALTIES FOR FALSIFYING INFORMATION (Continued)

6. 18 U.S.C. 1347 authorizes criminal penalties against individuals who knowing and willfully execute, or attempt, to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by or under the control of any, health care benefit program in connection with the delivery of or payment for health care benefits, items, or services. Individuals shall be fined or imprisoned up to 10 years or both. If the violation results in serious bodily injury, an individual will be fined or imprisoned up to 20 years, or both. If the violation results in death, the individual shall be fined or imprisoned for any term of years or for life, or both.
7. The government may assert common law claims such as “common law fraud,” “money paid by mistake,” and “unjust enrichment.”

Remedies include compensatory and punitive damages, restitution, and recovery of the amount of the unjust profit.

SECTION 15: CERTIFICATION STATEMENT

An **AUTHORIZED OFFICIAL** means an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** means an individual who is delegated by an authorized official the authority to report changes and updates to the supplier's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in Section 1124(a)(3) of the Social Security Act) or be a W-2 managing employee of the supplier.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the supplier's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in Section 15B.

NOTE: Authorized officials and delegated officials must be reported in Section 6 either on this application or on a previous application to this same Medicare fee-for-service contractor. **If this is the first time an authorized and/or delegated official has been reported on the CMS-855B, you must complete Section 6 for that individual.**

By his/her signature(s), an authorized official binds the supplier to all of the requirements listed in the Certification Statement and acknowledges that the supplier may be denied entry to or revoked from the Medicare program if any requirements are not met. All signatures must be original and in ink. Faxed, photocopied, or stamped signatures will not be accepted.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the supplier or (2) the enrollment application that must be submitted as part of the periodic revalidation process. A delegated official does not have this authority.

By signing this application, an authorized official agrees to immediately notify the Medicare fee-for-service contractor if any information in the application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the Medicare fee-for-service contractor of any future changes to the information contained in this form, after the supplier is enrolled in Medicare, within 90 days of the effective date of the change.

The supplier can have as many authorized officials as it wants. If the supplier has more than two authorized officials, it should copy and complete this section as needed.

**EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE
AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.**

SECTION 15: CERTIFICATION STATEMENT (Continued)

A. ADDITIONAL REQUIREMENTS FOR MEDICARE ENROLLMENT

These are additional requirements that the supplier must meet and maintain in order to bill the Medicare program. Read these requirements carefully. By signing, the supplier is attesting to having read the requirements and understanding them.

By his/her signature(s), the authorized official(s) named below and the delegated official(s) named in Section 16 agree to adhere to the following requirements stated in this Certification Statement:

1. I agree to notify the Medicare contractor of any future changes to the information contained in this application within 90 days of the effective date of the change. I understand that any change in the business structure of this supplier may require the submission of a new application.
2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare Identification Number(s), and/or the imposition of fines, civil damages, and/or imprisonment.
3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the supplier's compliance with all applicable conditions of participation in Medicare.
4. Neither this supplier, nor any five percent or greater owner, partner, officer, director, managing employee, authorized official, or delegated official thereof is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from supplying services to Medicare or other Federal program beneficiaries.
5. I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.
6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
7. I authorize any national accrediting body whose standards are recognized by the Secretary as meeting the Medicare program participation requirements, to release to any authorized representative, employee, or agent of the Centers for Medicare & Medicaid Services (CMS) a copy of my most recent accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

SECTION 15: CERTIFICATION STATEMENT (Continued)**B. 1ST AUTHORIZED OFFICIAL SIGNATURE**

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number			
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)			Date Signed (mm/dd/yyyy)

C. 2ND AUTHORIZED OFFICIAL SIGNATURE

I have read the contents of this application. My signature legally and financially binds this supplier to the laws, regulations, and program instructions of the Medicare program. By my signature, I certify that the information contained herein is true, correct, and complete and I authorize the Medicare fee-for-service contractor to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the Medicare fee-for-service contractor of this fact immediately.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Authorized Official's Information and Signature

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Telephone Number			
Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)			Date Signed (mm/dd/yyyy)

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

- You are not required to have a delegated official. However, if no delegated official is assigned, the authorized official(s) will be the only person(s) who can make changes and/or updates to the supplier's status in the Medicare program.
- The signature of a delegated official shall have the same force and effect as that of an authorized official, and shall legally and financially bind the supplier to the laws, regulations, and program instructions of the Medicare program. By his or her signature, the delegated official certifies that he or she has read the Certification Statement in Section 15 and agrees to adhere to all of the stated requirements. A delegated official also certifies that he/she meets the definition of a delegated official. When making changes and/or updates to the supplier's enrollment information maintained by the Medicare program, a delegated official certifies that the information provided is true, correct, and complete.
- Delegated officials being deleted do not have to sign or date this application.
- Independent contractors are not considered "employed" by the supplier, and therefore cannot be delegated officials.
- The signature(s) of an authorized official in Section 16 constitutes a legal delegation of authority to all delegated official(s) assigned in Section 16.
- If there are more than two individuals, copy and complete this section for each individual.

A. 1ST DELEGATED OFFICIAL SIGNATURE

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			
Delegated Official First Name	Middle Initial	Last Name	Suffix (<i>e.g., Jr., Sr.</i>)
Delegated Official Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i>)			Date Signed (mm/dd/yyyy)
<input type="checkbox"/> Check here if Delegated Official is a W-2 Employee		Telephone Number	
Authorized Official's Signature Assigning this Delegation (<i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i>)			Date Signed (mm/dd/yyyy)

SECTION 16: DELEGATED OFFICIAL (OPTIONAL)

B. 2ND DELEGATED OFFICIAL SIGNATURE

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			
Delegated Official First Name	Middle Initial	Last Name	Suffix (<i>e.g., Jr., Sr.</i>)
Delegated Official Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i>)			Date Signed (mm/dd/yyyy)
<input type="checkbox"/> Check here if Delegated Official is a W-2 Employee		Telephone Number	
Authorized Official's Signature Assigning this Delegation (<i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i>)			Date Signed (mm/dd/yyyy)

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this completed enrollment application. If you are newly enrolling, reactivating or revalidating your enrollment you must provide all applicable documents. For changes, only submit documents that are applicable to the change requested. You may submit a notarized Certificate of Good Standing from your State licensing/certification board or other medical associations in lieu of copies of business licenses, certifications, and/or registrations as required in your State. This certification cannot be more than 30 days old.

The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- Licenses, certifications and registrations required by Medicare or State law.
- Federal, State, and/or local (city/county) business licenses, certifications and/or registrations required to operate a health care facility.
- Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS CP 575) provided in Section 2.
- Completed Form CMS-588, Authorization Agreement for Electronic Funds Transfer. Note: If a supplier already receives payments electronically and is not making a change to its banking information, the CMS-588 is not required.
- Copy of the National Provider Identifier (NPI) notification that you received from the National Plan and Provider Enumeration System (NPPES).

MANDATORY FOR SELECTED PROVIDER/SUPPLIER TYPES

- Copy(s) of Lease Agreement for PT/OT Services.
- Copy(s) of all CLIA Certificates, FDA Mammography Certificates, and Diabetes Education Certificates.
- Copy(s) of all health care related permits/licenses/registrations for mobile health care services rendered inside a vehicle.
- Copy(s) of all documentation verifying IDTF Supervisory Physician(s) proficiency.

MANDATORY, IF APPLICABLE

- Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- Copy(s) of all adverse legal action documentation (e.g., notifications, resolutions, and reinstatement letters).
- Completed Form(s) CMS 855R, Reassignment of Medicare Benefits.
- Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- Copy of delegated official's W-2 if you have designated a delegated official.
- Copy of an attestation for government entities and tribal organizations.
- Copy of FAA 135 certificate (air ambulance suppliers).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to 6 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DO NOT MAIL APPLICATIONS TO THIS ADDRESS. Mailing your application to this address will significantly delay application processing.

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS

All ambulance service suppliers enrolling in the Medicare program must complete this attachment.

A. GEOGRAPHIC AREA

This section is to be completed with information about the geographic area in which this company provides ambulance services. If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Provide the city/town, State, and ZIP code for all locations where this ambulance company renders services.

NOTE: If the ambulance company has vehicles garaged within a different Medicare contractor's jurisdiction, a separate CMS-855B enrollment application will need to be submitted to that Medicare contractor.

1. INITIAL REPORTING AND/OR ADDITIONS

If services are provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

City/Town	State	ZIP Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. DELETIONS

If services are no longer provided in selected cities/towns, provide the locations below. List ZIP codes only if they are not within the entire city/town.

City/Town	State	ZIP Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (Continued)

B. STATE LICENSE INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

Crew members must complete continuing education requirements in accordance with State and local licensing laws. Evidence of re-certification must be retained with the employer in case it is required by the Medicare contractor.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Is this ambulance company licensed in the State where services are rendered and billed for? YES NO

If **NO**, explain why:

If **YES**, provide the license information for the State where this ambulance service supplier will be rendering services and billing Medicare. Attach a copy of the current State license.

License Number	Issuing State (if applicable)	Issuing City/Town (if applicable)
Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	

C. PARAMEDIC INTERCEPT SERVICES INFORMATION

Paramedic Intercept Services involve an arrangement between a Basic Life Support (BLS) ambulance company and an Advanced Life Support (ALS) ambulance company whereby the latter provides the ALS services and the BLS ambulance company provides the transportation component. If such an arrangement exists between the enrolling ambulance company and another ambulance company, the enrolling ambulance company must attach a copy of the signed contract. For more information, see 42 CFR 410.40.

If reporting a change to information about a previously reported agreement/contract, check “Change” and provide the effective date of the change.

Change Effective Date: _____

Does this ambulance company currently participate in a paramedic intercept services arrangement? YES NO

ATTACHMENT 1: AMBULANCE SERVICE SUPPLIERS (Continued)

D. VEHICLE INFORMATION

Complete this section with information about the vehicles used by this ambulance company and the services they provide. If there is more than one vehicle, copy and complete this section as needed. Attach a copy of each vehicle registration.

To qualify as an air ambulance supplier, the following is required:

- A written statement, signed by the President, Chief Executive Officer or Chief Operating Officer of the airport from where the aircraft is hangared that gives the name and address of the facility, and
- Proof that the enrolling ambulance company, or the company leasing the air ambulance vehicle to the enrolling ambulance company, possesses a valid charter flight license (FAA 135 Certificate) for the aircraft being used as an air ambulance. If the enrolling ambulance company owns the aircraft, the owner's name on the FAA 135 Certificate must be the same as the enrolling ambulance company's name (or the ambulance company owner as reported in Sections 5 or 6) in this application. If the enrolling ambulance company leases the aircraft from another company, a copy of the lease agreement must accompany this enrollment application.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

Type (automobile, aircraft, boat, etc.)		Vehicle Identification Number	
Make (e.g., Ford)	Model (e.g., 350T)	Year (yyyy)	

Does this vehicle provide:

Advanced life support (Level 1)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Specialty care transport	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Advanced life support (Level 2)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Land ambulance	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Basic life support	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Air ambulance—fixed wing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emergency runs	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Air ambulance—rotary wing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Non-emergency runs	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Marine ambulance	<input type="checkbox"/> YES	<input type="checkbox"/> NO

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs)

If you perform diagnostic tests, other than clinical laboratory or pathology tests, and are required to enroll as an IDTF, you **must** complete this attachment. CMS requires the information in this attachment to determine whether the enrolling supplier meets all IDTF standards. Not all suppliers that perform diagnostic tests are required to enroll as an IDTF.

DIAGNOSTIC RADIOLOGY

Many diagnostic tests are radiological procedures that require the professional services of a radiologist. A radiologist's practice is generally different from those of other physicians because radiologists usually do not bill E&M codes or treat a patient's medical condition on an ongoing basis. A radiologist or group practice of radiologists is not necessarily required to enroll as an IDTF. If enrolling as a diagnostic radiology group practice or clinic and billing for the technical component of diagnostic radiological tests without enrolling as an IDTF (if the entity is a free standing diagnostic facility), it should contact the carrier to determine that it does not need to enroll as an IDTF.

A mobile IDTF that provides X-ray services is not classified as a portable X-ray supplier.

Regulations governing IDTFs can be found at 42 CFR 410.33.

AMBULATORY SURGICAL CENTERS (ASCs)

There are limited instances where an IDTF, or an entity that owns both an IDTF and ASC, can bill for IDTF services at an ASC facility location. These instances generally involve: (1) IDTF operation in the same physical facility as the ASC, but during a time period when the ASC is not in operation, and/or (2) imaging and guidance services provided in conjunction with ASC-performed surgical procedures. Applicants should discuss these matters with their potential fee-for-service contractor to determine if separate IDTF billings and enrollment are applicable.

SERVICE PERFORMANCE

Standards Qualifications—All IDTFs must meet current CMS standards as an IDTF prior to enrollment. The enrolling IDTF must provide the date it met all current IDTF standards. This date may be used as the effective date for claims payment if the enrolling IDTF can provide evidence (e.g., personnel and equipment records) that they met the standards on that date.

CPT-4 and HCPCS Codes—Report all CPT-4 and HCPCS codes for which this IDTF will bill Medicare. Include the following:

- Provide the CPT-4 or HCPCS codes for which this IDTF intends to bill Medicare,
- The name and type of equipment used to perform the reported procedure, and
- The model number of the reported equipment.

The IDTF should report all Current Procedural Terminology, Version 4 (CPT-4) codes, Healthcare Common Procedural Coding System codes (HCPCS), and types of equipment (including the model number), for which it will perform tests, supervise, interpret, and/or bill. All codes reported must be for diagnostic tests that an IDTF is allowed to perform. Specifically, diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

A. STANDARDS QUALIFICATIONS

Provide the date this Independent Diagnostic Testing Facility met all current CMS standards (mm/dd/yyyy): _____

B. CPT-4 AND HCPCS CODES

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

All codes reported here must be for diagnostic tests that an IDTF is allowed to perform. Specifically, diagnostic tests that are clearly surgical in nature, which must be performed in a hospital or ambulatory surgical center, should not be reported. Clinical laboratory and pathology codes should not be reported. This page may be copied for additional codes or equipment.

CPT-4 or HCPCS Code	Equipment	Model Number (Required)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

C. INTERPRETING PHYSICIAN INFORMATION

CHECK HERE if this section does not apply because the interpreting physician will bill separate from the IDTF.

All physicians whose interpretations will be billed by this IDTF with the technical component (TC) of the test (i.e., global billing) must be listed in this section. If there are more than three physicians, copy and complete this section as needed. All interpreting physicians must be currently enrolled in the Medicare program.

If you are billing for interpretations as an individual reassigning benefits, the interpreting physician must complete the Reassignment of Benefits Form (CMS 855R). Note: Both the IDTF and individual physician must be enrolled with the fee-for-service contractor where the IDTF is located.

If you are billing for purchased interpretations, all requirements for purchased interpretations must be met.

When a mobile unit of the IDTF performs a technical component of a diagnostic test and the interpretive physician is the same physician who ordered the test, the IDTF cannot bill for the interpretation. Therefore, these interpreting physicians should not be reported since the interpretive physician must submit his/her own claims for these tests.

1ST INTERPRETING PHYSICIAN INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	
Medicare Identification Number (if issued)		NPI	

2ND INTERPRETING PHYSICIAN INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	
Medicare Identification Number (if issued)		NPI	

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

3RD INTERPRETING PHYSICIAN INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	
Medicare Identification Number (if issued)		NPI	

D. PERSONNEL (TECHNICIANS) WHO PERFORM TESTS

Complete this section with information about all non-physician personnel who perform tests for this IDTF. If there are more than two technicians, copy and complete this section as needed.

If a reported technician does not have either a State license or certification, or certification from a national credentialing body, he/she cannot perform the IDTF diagnostic tests and should not be reported. The only exception to this is when there is no State license or certification and there is no generally accepted national credentialing body. When this situation occurs, the technician performing the test must be reported. The IDTF must submit as an attachment any educational/credentialing and/or experience that the person has. Notarized or certified true copies of the State license or certificate should be attached.

1ST PERSONNEL (TECHNICIAN) INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number (Required)		Date of Birth (mm/dd/yyyy) (Required)	

Is this technician State licensed or State certified? (see instructions for clarification) YES NO

License/Certification Number (if applicable)	License/Certification Issue Date (mm/dd/yyyy) (if applicable)
--	---

Is this technician certified by a national credentialing organization? YES NO

Name of credentialing organization (if applicable)	Type of Credentials (if applicable)
--	-------------------------------------

Is this technician employed by a hospital? YES NO
 If YES, provide the name of the hospital here: _____

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

2ND PERSONNEL (TECHNICIAN) INFORMATION

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			

First Name	Middle Initial	Last Name	Suffix (<i>e.g., Jr., Sr.</i>)
Social Security Number (<i>Required</i>)		Date of Birth (<i>mm/dd/yyyy</i>) (<i>Required</i>)	

Is this technician State licensed or State certified? (*see instructions for clarification*) YES NO

License/Certification Number (<i>if applicable</i>)	License/Certification Issue Date (<i>mm/dd/yyyy</i>) (<i>if applicable</i>)
---	---

Is this technician certified by a national credentialing organization? YES NO

Name of credentialing organization (<i>if applicable</i>)	Type of Credentials (<i>if applicable</i>)
---	--

Is this technician employed by a hospital? YES NO
 If **YES**, provide the name of the hospital here: _____

E. SUPERVISING PHYSICIANS

Complete this section with identifying information about the physician(s) who supervise the operation of the IDTF and who provides the personal, direct, or general supervision per 42 CFR 410.32(b)(3). The supervising physician must also attest to his/her supervising responsibilities for the enrolling IDTF.

Information concerning the type of supervision (personal, direct, or general) required for performance of specific IDTF tests can be obtained from your Medicare fee-for-service contractor. All IDTFs must report at least one supervisory physician, and at least one supervising physician must perform the supervision requirements stated in 42 CFR 410.32(b)(3). All supervisory physician(s) must be currently enrolled with Medicare.

The type of supervision being performed by each physician who signs the attestation on page 44 of this application should be listed in this section.

Definitions of the types of supervision are as follows:

Personal Supervision means a physician must be in attendance in the room during the performance of the procedure.

Direct Supervision means the physician must be present in the office suite and immediately available to provide assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

General Supervision means the procedure is provided under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. General supervision also includes the responsibility that the non-physician personnel who perform the tests are qualified and properly trained and that the equipment is operated properly, maintained, calibrated and that necessary supplies are available.

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

E. SUPERVISING PHYSICIANS (Continued)

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	<input type="checkbox"/> CHANGE	<input type="checkbox"/> ADD	<input type="checkbox"/> DELETE
DATE (mm/dd/yyyy)			
First Name	Middle Initial	Last Name	Suffix (e.g., Jr., Sr.)
Social Security Number <i>(Required)</i>		Date of Birth (mm/dd/yyyy) <i>(Required)</i>	
Medicare Identification Number <i>(if issued)</i>		NPI	
Telephone Number	Fax Number <i>(if applicable)</i>	E-mail Address <i>(if applicable)</i>	

TYPE OF SUPERVISION PROVIDED

Check the appropriate box below indicating the type of supervision provided by the physician reported above for the tests performed by the IDTF in accordance with 42 CFR 410.32 (b)(3) (See instructions for definitions).

- Personal Supervision
 Direct Supervision
 General Supervision

For each physician performing General Supervision, at least one of the three functions listed here must be checked. However, to meet the General Supervision requirement, in accordance with 42 CFR 410.33(b), the enrolling IDTF must have at least one supervisory physician for each of the three functions. For example, two physicians may be responsible for function 1, a third physician may be responsible for function 2, and a fourth physician may be responsible for function 3. All four supervisory physicians must complete and sign the supervisory physician section of this application. Each physician should only check the function(s) he/she actually performs.

- Assumes responsibility for the overall direction and control of the quality of testing performed.
- Assumes responsibility for assuring that the non-physician personnel who actually perform the diagnostic procedures are properly trained and meet required qualifications.
- Assumes responsibility for the proper maintenance and calibration of the equipment and supplies necessary to perform the diagnostic procedures.

OTHER SUPERVISION SITES

Does this supervising physician provide supervision at any other IDTF? YES NO

If yes, list all other IDTFs for which this physician provides supervision. For more than five, copy this sheet.

	Name of Facility	Address	Tax Identification Number	Level of Supervision
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

ATTACHMENT 2: INDEPENDENT DIAGNOSTIC TESTING FACILITIES (Continued)

E. SUPERVISING PHYSICIANS (Continued)

ATTESTATION STATEMENT FOR SUPERVISING PHYSICIANS

All Supervising Physician(s) rendering supervisory services for this IDTF must sign and date this section. All signatures must be original.

1. I hereby acknowledge that I have agreed to provide (IDTF Name) _____ with the Supervisory Physician services checked above for all CPT-4 and HCPCS codes reported in this Attachment (See number 2 below if all reported CPT-4 and HCPCS codes do not apply). I also hereby certify that I have the required proficiency in the performance and interpretation of each type of diagnostic procedure, as reported by CPT-4 or HCPCS code in this Attachment (except for those CPT-4 or HCPCS codes identified in number 2 below). I have read and understand the Penalties for Falsifying Information on this Enrollment Application, as stated in Section 14 of this application. I am aware that falsifying information may result in fines and/or imprisonment. If I undertake supervisory responsibility at any additional IDTFs, I understand that it is my responsibility to notify this IDTF at that time.
2. I am not acting as a Supervising Physician for the following CPT-4 and/or HCPCS codes reported in this Attachment.

CPT-4 or HCPCS Code	CPT-4 or HCPCS Code	CPT-4 or HCPCS Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Signature of Supervising Physician (*First, Middle, Last, Jr., Sr., M.D., D.O., etc.*)

Date (*mm/dd/yyyy*)

All signatures must be original and signed and dated in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

MEDICARE SUPPLIER ENROLLMENT APPLICATION PRIVACY ACT STATEMENT

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect the information requested on this form by sections 1124(a)(1), 1124A(a)(3), 1128, 1814, 1815, 1833(e), and 1842(r) of the Social Security Act [42 U.S.C. §§ 1320a-3(a)(1), 1320a-7, 1395f, 1395g, 1395(l)(e), and 1395u(r)] and section 31001(1) of the Debt Collection Improvement Act [31 U.S.C. § 7701(c)].

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to enroll in the Medicare program as suppliers of goods and services to Medicare beneficiaries and to assist in the administration of the Medicare program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation in the Medicare program. All information on this form is required, with the exception of those sections marked as “optional” on the form. Without this information, the ability to make payments will be delayed or denied.

The information collected will be entered into the Provider Enrollment, Chain and Ownership System (PECOS), and system number 09-70-0525 titled Unique Physician/Practitioner Identification Number (UPIN) System (published in Vol. 61 of the Federal Register at page 20,528 (May 7, 1996)). The information in this application will be disclosed according to the routine uses described below.

Information from these systems may be disclosed under specific circumstances to:

1. CMS contractors to carry out Medicare functions, collating or analyzing data, or to detect fraud or abuse;
2. A congressional office from the record of an individual health care provider in response to an inquiry from the congressional office at the written request of that individual health care practitioner;
3. The Railroad Retirement Board to administer provisions of the Railroad Retirement or Social Security Acts;
4. Peer Review Organizations in connection with the review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XVIII of the Social Security Act;
5. To the Department of Justice or an adjudicative body when the agency, an agency employee, or the United States Government is a party to litigation and the use of the information is compatible with the purpose for which the agency collected the information;
6. To the Department of Justice for investigating and prosecuting violations of the Social Security Act, to which criminal penalties are attached;
7. To the American Medical Association (AMA), for the purpose of attempting to identify medical doctors when the Unique Physician Identification Number Registry is unable to establish identity after matching contractor submitted data to the data extract provided by the AMA;
8. An individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or to the restoration or maintenance of health;
9. Other Federal agencies that administer a Federal health care benefit program to enumerate/enroll providers of medical services or to detect fraud or abuse;
10. State Licensing Boards for review of unethical practices or non-professional conduct;
11. States for the purpose of administration of health care programs; and/or
12. Insurance companies, self insurers, health maintenance organizations, multiple employer trusts, and other health care groups providing health care claims processing, when a link to Medicare or Medicaid claims is established, and data are used solely to process supplier’s health care claims.

The enrolling supplier should be aware that the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) amended the Privacy Act, 5 U.S.C. § 552a, to permit the government to verify information through computer matching.

Protection of Proprietary Information

Privileged or confidential commercial or financial information collected in this form is protected from public disclosure by Federal law 5 U.S.C. § 552(b)(4) and Executive Order 12600.

Protection of Confidential Commercial and/or Sensitive Personal Information

If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.